CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Healthcare Facilities Management

(New Administrative Regulation)

907 KAR 3:230. Reimbursement policies and requirements for specialty intermediate care (IC) clinic services.

RELATES TO: KRS 216B.450 through 459, 42 CFR Part 413, 42 CFR 447.204, 42 CFR 447.321

STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), and 205.560(2)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the reimbursement policies and requirements for covered specialty intermediate care clinic services provided to a Medicaid recipient who is not enrolled with a managed care organization and optional policies for covered specialty IC clinic services provided to a Medicaid recipient who is enrolled with a managed care organization.

Section 1. Definitions. (1) “Bad debt” means accounts receivable which will likely remain uncollected.

(2) “Department” means the Department for Medicaid Services or its designee.

(3) “Federal financial participation” is defined in 42 CFR 400.203.

(4) “Government Auditing Standards” means the standards:

(a) For audits of government organizations, programs, activities, functions, and of government assistance received by contractors, nonprofit organizations, and other nongovernment organizations;

(b) Often referred to as generally accepted government auditing standards or GAGAS; and

(c) Accessible at the website of http://www.gao.gov/govaud/ybk01.htm.

(5) “Medically necessary” means determined by the department to be needed in accordance with 907 KAR 3:130.

(6) “Specialty intermediate care clinic” or “specialty IC clinic” means a clinic located on the grounds of a state-owned facility licensed pursuant to 902 KAR 20:086 as an intermediate care facility for individuals with an intellectual disability.

(7) “Recipient” is defined by KRS 205.8451(9).

Section 2. Interim Reimbursement. (1)(a) Except for a specialty IC clinic’s first fiscal year of operation, the department shall reimburse on an interim basis:

1. For specialty intermediate care clinic services via an interim rate and utilizing a clinic-specific cost-to-charge ratio:

a. For each service;

b. Based on the clinic’s most recently filed cost report, unless no cost report

exists; and

c. Expressed as a percent of the clinic's charges; and

2. During the course of a state fiscal year until the most recent full fiscal year cost report from the clinic has been finalized by the department.

(b) The department shall use projected costs to establish interim rates for the first fiscal year of a specialty IC clinic's operation.

(2) The department shall determine a:

(a) Clinic-specific cost-to-charge ratio for each service; and

(b) Specialty IC clinic's interim rate for a service by:

1. Multiplying the total charges for the service by the service-specific cost-to-charge ratio; and

2. Dividing the number established pursuant to subparagraph 1. of this paragraph by the applicable number of service units. For example, $500,000 in total charges multiplied by a cost-to-charge ratio of 0.95 divided by 10,000 units equals an interim rate of $47.50.

(3) An interim rate for a fiscal year shall be effective on July 1 of a calendar year and remain in effect until close of business June 30 of the subsequent calendar year.

(4)(a) The department shall adjust an interim rate if:

1. The department miscalculated a specialty IC clinic's interim rate;

2. A specialty IC clinic submits an amended cost report which applies to the interim rate period; or

3. A further desk or on-site audit of a cost report used to establish the interim rate discloses a change in allowable costs.

(b) The department shall not adjust an interim rate for a reason not described in subparagraph 1, 2, or 3 of this paragraph.

(5) The department shall use the most recently received ICF-IID and Specialty Intermediate Care Clinic Cost Report as of March 15 to establish interim rates for a specialty IC clinic to be effective on July 1 of a given year.

Section 3. Final Reimbursement. (1) After the most recent full fiscal year cost report for a specialty IC clinic has been finalized by the department, the department shall cost settle with the clinic to establish final reimbursement to the clinic for the corresponding fiscal year.

(2) A cost settlement between the department and a specialty IC clinic shall:

(a) Be limited to an amount, if any, by which the specialty IC clinic's allowable costs exceeds the amount of:

1. Any third party recovery during the fiscal year; and

2. Interim payments made to the specialty IC clinic; and

(b) Not exceed the federal upper payment limit in accordance with 42 CFR 447.321.

(3)(a) The department's reimbursement to a specialty IC clinic shall be payment in full to the specialty IC clinic for services provided to recipients.

(b) A specialty IC clinic shall not bill a recipient for a service provided to a recipient.

(c) A bad debt shall not be:

1. An allowable cost; or

2. Reimbursable by the department.

Section 4. Cost Reporting Requirements. (1)(a) A specialty IC clinic shall annually submit to the department a fully completed ICF-IID and Specialty Intermediate Care

Clinic Cost Report within four (4) calendar months of the end of the prior state fiscal year.

(b) For example, an ICF-IID and Specialty Intermediate Care Clinic Cost Report covering the fiscal year end June 30, 2013 shall be submitted to the department by close of business October 31, 2013.

(2) A specialty IC clinic shall complete an ICF-IID and Specialty Intermediate Care Clinic Cost Report in accordance with the ICF-IID and Specialty Intermediate Care Clinic Cost Report Instructions.

(3) Interim reimbursement for a specialty IC clinic which does not submit a legible and complete ICF-IID and Specialty Intermediate Care Clinic Cost Report to the department within the time period referenced in subsection (1) of this section, shall be placed in escrow by the department until the department receives a legible and completed ICF-IID and Specialty Intermediate Care Clinic Cost Report.

(4) After finalizing the first full fiscal year cost report submitted by a facility, the department shall establish an interim rate based on the first full year cost report.

(5)(a) An ICF-IID and Specialty Intermediate Care Clinic Cost Report shall include the statement stated in paragraph (b) of this subsection and the statement shall immediately precede the dated signature of the specialty IC clinic's administrator or chief financial officer.

(b) "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Kentucky Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were reported in compliance with such laws and

regulations. This cost report includes total computable cost incurred to provide Medicaid services.”

(6) If a cost report indicates a payment is due by a specialty IC clinic to the department, the specialty IC clinic shall submit the amount due or submit a payment plan request with the cost report.

(7) If a cost report indicates a payment is due by a specialty IC clinic to the department and the specialty IC clinic fails to remit the amount due or request a payment plan, the department shall suspend future payment to the specialty IC clinic until the specialty IC clinics remits the payment or submits a request for a payment plan.

(8)(a) If it is determined that an additional payment is due by a specialty IC clinic after a final determination of cost has been made by the department, the additional payment shall be due by the specialty IC clinic to the department within sixty (60) days after notification.

(b) If a specialty IC clinic does not submit the additional payment within sixty (60) days, the department shall withhold future payment to the specialty IC clinic until the department has collected in full the amount owed by the specialty IC clinic to the department.

(9)(a) A specialty IC clinic shall report all of its costs, allowable costs, and unallowable costs on a cost report.

(b) The department shall not reimburse for or cost settle unallowable costs.

Section 5. Allowable and Unallowable Costs. (1) An allowable cost shall:

(a) Be allowable in accordance with 42 CFR Part 413;

(b) Be a cost allowed after an audit by the department; and

(c) Include:

1. A cost incurred by a specialty IC clinic in meeting and maintaining health standards pursuant to 42 CFR 431.610(c); and

2. Costs resulting from meeting Kentucky specialty clinic licensure requirements pursuant to 902 KAR 20:410.

(2) Reimbursable services shall be the specialty IC clinic services established in 907 KAR 3:225.

(3) Costs relating to unallowable clinic activities shall:

(a) Be excluded from any cost settlement;

(b) Not be reimbursable; and

(c) Reported separately on a cost report.

Section 6. Audits. (1) An ICF-IID and Specialty Intermediate Care Clinic Cost Report and all related documents submitted to the department by a specialty IC clinic shall be subject to audit, review, and reconciliation by the department.

(2) An audit, if performed, shall be performed in accordance with the most current Government Auditing Standards available via the website of http://www.gao.gov/govaud/ybk01.htm.

Section 7. Pharmacy, Medication, Immunization, and Other Costs Not Reimbursed at Cost. (1) The department shall reimburse for:

(a) Prescription drug costs experienced by a specialty IC clinic through the department's pharmacy program in accordance with 907 KAR 1:018.

(b) Immunization costs experienced by a specialty IC clinic through the department's physicians' program in accordance with 907 KAR 3:010.

(2) Medication:

(a) Consultation costs shall be allowable; and

(b) Management costs shall be allowable.

Section 8. Not Applicable to Managed Care Organizations. (1) A managed care organization may elect to reimburse for specialty IC clinic services in accordance with this administrative regulation.

(2) The reimbursement policies established in this administrative regulation shall not apply to a managed care organization.

Section 9. Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

(1) Denies federal financial participation for the policy; or

(2) Disapproves the policy.

Section 10. Appeals. (1) An interim rate adjustment or denial of an interim rate adjustment may be appealed in accordance with 907 KAR 1:671.

(2) A Medicaid program sanction or appeal shall be in accordance with 907 KAR 1:671.

Section 11. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) The “ICF-IID and Specialty IC Clinic Cost Report”, March 2013 edition; and

(b) The " ICF-IID and Specialty IC Clinic Cost Report Instructions”, March 2013 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40601, Monday through Friday 8 a.m. to 4:30 p.m.

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REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

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PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on June 21, 2013, at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing June 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business July 1, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 3:230
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This is a new administrative regulation which establishes Medicaid reimbursement policies and requirements for specialty intermediate care (IC) clinic services.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Medicaid reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing Medicaid reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and

local government affected by this administrative regulation: Affected individuals include Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability but who may be able to transition to a community setting as a result of this administrative regulation. Additionally, any Medicaid recipients already living in a community setting and who need specialty IC clinic services could be affected. Lastly, the clinics themselves will be affected. One (1) facility – located in Louisville, has already been constructed and the start of construction for another facility – in Somerset, KY – is anticipated to begin in June 2013.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Specialty IC clinics will have to annually submit an ICF-IID and Specialty Intermediate Care Clinic Cost Report to DMS in order to be reimbursed for specialty IC clinic services provided to Medicaid recipients.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed on the regulated entities.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients currently residing in an intermediate care facility for individuals with an intellectual disability but who may be able to transition to a community setting as a result of this administrative regulation would benefit. Additionally, any Medicaid recipients already living in a community setting and who need specialty IC clinic services could benefit by the expanded access to services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services estimates that implementing this administrative regulation will cost DMS $600,000 per month (state and federal combined) for each month of implementation in state fiscal year 2013.

(b) On a continuing basis: DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds from state general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it

is an amendment: Neither an increase in fees nor funding are necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is not applied as the regulated entities are regulated uniformly by this administrative regulation.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 3:230
Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services and the Department for Behavioral Health, Developmental and Intellectual Disabilities will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation is necessary to establish Medicaid reimbursement policies and requirements for specialty IC clinics related to a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS projects no revenue to be generated by the administrative regulation.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS projects no revenue to be generated by the administrative regulation.
   (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services estimates that implementing this administrative regulation will cost DMS $600,000 (state and federal combined) for each month of implementation in state fiscal year 2013.
   (d) How much will it cost to administer this program for subsequent years? DMS projects that implementing the administrative regulation will cost approximately $7.2 million (state and federal combined) annually.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):
Expenditures (+/-):
Other Explanation:

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 3:230
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1. Federal statute or regulation constituting the federal mandate. The mandate source is a settlement agreement between the Cabinet for Health and Family Services and the United States Department of Justice's Division of Civil Rights. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. The strategic action plan incorporated by reference into the settlement agreement mandated the establishment of specialty intermediate care clinics on the grounds of intermediate care facilities for the intellectually and developmentally disabled as a means of serving individuals in the most integrated setting appropriate to their needs.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 3:230

Summary of Material Incorporated by Reference

The following material is incorporated by reference:

1. The “ICF-IID and Specialty IC Clinic Cost Report,” March 2013 edition. This document is submitted by specialty IC clinics to the Department for Medicaid Services to establish final reimbursement for the clinic for a given fiscal year. The document contains 718 pages.

2. The “The “ICF-IID and Specialty IC Clinic Cost Report Instructions,” March 2013 edition. This document is used to instruct staff how to complete a ICF-IID and Specialty Intermediate Care Clinic Cost Report. The document contains twenty (20) pages.

A total of 738 pages (on a CD) are incorporated by reference into this administrative regulation.